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ABSTRACT

This study examined the problems of using conventional and traditional forms of psychotherapeutic and counseling interventions with American Indians and Alaska natives. Cultural specific forms of psychological and behavioral intervention and prevention have existed in Indian and Native communities for centuries. Vestiges of traditional healing and treatment ceremonies persist to this day although many have been revised to accommodate contemporary lifestyles. Numerous Indian and Native communities are working through a variety of prevention and intervention schemes in an effort to deal with drug and alcohol use. The communities rely heavily on the conventional wisdom and methods of the substance abuse research field; however, the community resource people recognize that intervention schemes must be adjusted to fit local tribal specific customs and norms. Cognitive-behavioral prevention, bicultural competence, and social skills enhancement perspectives were brought together to form a drug use prevention-intervention strategy tailored for use with Indian youth. As a stand alone prevention-intervention strategy the cognitive-behavioral perspective probably would not be very useful. The content of the components, exercises, interpersonal communication styles, and didactic approaches must be adjusted to fit the cultural lifeways of a community. Local people also must be included in the planning and curriculum adjustment and modification phase, and they should be trained to serve as group leaders. The cognitive-behavioral skills enhancement prevention strategy, therefore, can be used in many culturally different communities. (LLL)

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Cognitive-Behavioral Skills Enhancement and Deterring Drug Abuse Among American Indians[1]

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Cognitive-Behavioral Skills Enhancement

and Deterring Drug Abuse Among American Indians

Introduction

Use of counseling and psychotherapeutic techniques with American Indians of all ages is fraught with numerous complications. The techniques themselves are built on a model heavily influenced by the wisdom and experiences of North American academicians and practitioners; and the majority of them acquired their knowledge and training in institutions whose structure and function almost mirror classic European traditions. Consider the following circumstances: 1) almost, if not all, early American clinicians and counselors were of European ethnic origin; 2) most counseling techniques were spawned in academic environments who largely catered to students who represented many varied generations of European heritage; and 3) most, if not all, of those counselors and clinicians responsible for developing counseling psychotherapeutic theories and techniques were caucasians. Hence, the emergence, promotion, and progressive growth of counseling and psychotherapy theory is culture bound and "culturally encapsulated" (Wrenn, 1962); the term implies that a cocoon of pretentious reality protects one against the struggle with the multitude of differences that abound in North America.

Problems With Conventional Intervention Approaches

For many North American Indians the essence of counseling and clinical theory creates problems. Self-disclosure, talking out feelings, fears, anxieties and intrapersonal problems, keeping a scheduled appointment to "talk" with someone who is not from their culture represent a small portion of a much more elaborate and extensive list of potential problems (LaFromboise, Trimble, and Mohatt, 1990). To a large extent, thought, the most problematic is the possibility that for many Indians counseling and clinical intervention techniques may be intrusive, invidious, and presumptuous; that is, the techniques offered and presented as though the individual and their community of origin had no effective means for dealing with emotional and behavioral problems and disorders. To the contrary it would be safe to conclude that virtually all American Indian sociolinguistic groups had time tested approaches for handling known forms of individual, familial, and community deviations from a group's

prevailing ethos and eidos. Such approaches for "classifying and categorizing forms of behavior fit closely within their world view and the view they (had) of themselves as people" (Trimble and Medicine, 1976, p. 13). Therefore, mental health and all that it represents in the conventional psychological and psychiatric literature probably means very different things to many American Indians (Trimble, Manson, Dinges, and Medicine, 1984). Moreover, many Indians firmly believe "that 'mental health' is much more spiritual and holistic than conventional psychological theory would suggest" (LaFromboise, Trimble, and Mohatt, 1990, p. 629).

The incompatibility between conventional counseling and psychotherapeutic and the "native world view" has received considerable attention in recent years (Attneave, 1969; Trimble, 1981; Manson and Trimble, 1982; Trimble and Hayes, 1984; LaFromboise, 1988; Trimble and Fleming, 1989). Much of the criticism draws attention to the heavy emphasis that conventional clinical techniques place on the self process and self insight. The emphasis tends to run against the social ecological flow of one's connectedness to the Indian community, the family, and the indigenous native network (Attneave, 1979; Trimble and Hayes, 1984). Moreover, for some Indians the therapeutic value-free environment is inconsistent with their needs and expectations since they may need someone to assist them in asserting their traditional values and belief system and define their problem within the context of that network (LaFromboise, Trimble, and Mohatt, 1990).

Many American Indians view illness or sickness as emanating outside the community ("white man's disease") or influenced by some aspect of their traditional view of causality (spirit intrusion, taboo violation, soul loss, ghost sickness, etc.). Traditional healers, shaman, medicine people and "Indian doctors" typically are assigned the responsibility for "treating" and curing the "Indian sicknesses." When an individual's problem is believed to emanate from a cause outside the community then assistance is sought from appropriate health agencies such as the Indian Health Service or urban Indian health centers (Manson and Trimble, 1982). For example, alcoholism and drug-abuse are viewed as "white man's diseases" and therefore, as the logic goes, it is the "white man" who is responsible for treating them.

"Indian Sickness and White Man's Disease"

Basing the diagnosis of disease on one or the other sociocultural lifeways presents an interesting problem for the nonIndian clinician. If a native oriented, traditional Indian, for example, is treated by a shaman for alcoholism or drug addiction and is successful then the healer is credited with the power to diagnose and treat a "white man's disease" (Powers, 1986). But if the patient doesn't respond then the blame is deflected away from the healer and projected onto public health authorities. Patients never die from "Indian sickness, the (healer) is always successful" (Powers, 1986, p. 178). If the patient is treated by a nonIndian clinician they can almost expect to experience failure since from a "traditionalist's" point of view they can never heal "Indian sicknesses." The clinician is also at a distinct disadvantage in treating clients since the world views of patient and therapist are known and believed to be different and at odds with one another; some expect differences to exist thereby fulfilling the expectation that nonIndian clinicians can never hope to be successful with Indian clients.

The apparent incompatibility between conventional counseling and clinical theory and practice and typical Indian world views is not altogether insolvable. The debate rolls on. Some small steps have been taken to develop some eclectic blend of divergent viewpoints in an effort to achieve some balance; such efforts are slow in developing and the results await further discussion and debate (LaFromboise, 1989; Beiser, 1985; Hammerschlag, 1988; Speck and Attneave, 1973). The one area, however, that presents the most difficulty is the prevention and treatment of the dreadful incidences of alcoholism and drug addiction occurring among American Indians, especially those in the adolescent developmental life span.

The generalized array of clinical and counseling problems discussed above coupled with the belief that alcoholism and drug addiction are "white man's diseases" compounds the use of effective prevention and intervention techniques and strategies among Indians. The remaining sections of this chapter focus on the subject of the prevention and treatment of drug abuse among Indian adolescents. Following a review of the scant literature on the topic information will be provided describing one approach to intervention that has shown some promise with Indian youth.

Drug Abuse and American Indian Concerns

For most American Indians and alaska Natives alcohol and drug abuse are considered to be their primary mental health and community problem. Sadly, the causal relationship between personal and social problems and the use and abuse of psychoactive substances is not clearly understood. Several theories and anecdotal explanations have been offered; few have been subjected to the rigors of scientific research (Trimble, Padilla, and Bell, 1987; Mail and McDonald, 1980). Some of the explanations put forth emphasize that drug abuse is a reaction to feelings of powerlessness (McClelland, David, Warner, and Kalin, 1966), peer influence and pressure (Oetting and Beauvais, 1987), tension reduction and coping with unpleasant and unwanted feelings (Segal, 1989), need to experiment and try out things that alter consciousness (Segal, Huba, and Singer, 1980), and an attempt to assert and validate one's Indianness (Lurie, 1971).

Incidence and Prevalence

Even though there are sparse results offered up to explain Indian drug use and abuse there is no lack of opinion and data describing its incidence and prevalence. Mail and McDonald (1980); identified and compiled over 950 annotated citations dealing solely with alcoholism; they note that "the indicators used for assessing problem drinking among Native Americans are by necessity mostly indirect and very unsatisfactory" (p. 2). A more current summary of the literature on Indian alcohol use was compiled by Lobb and Watts (1989) who show that the literature tends to be more multidisciplinary than ever and that a number of once firmly held notions about Indian drinking behavior are being challenged.

Watts and Lewis (1988) point out that "the subject of alcohol and native (sic) American youth, has been a long, tortured second trail of tears" (p. 81). More than any other American ethnic group Indian and Native youth and adults appear to bear the brunt of alcohol and drug abuse problems. The most extensive study on drug use and abuse among Indian youth was conducted by Oetting and his colleagues at Colorado State University (Oetting, Edwards, and Beauvais, 1989). Based on their findings over a ten year period the researchers found that alcohol clearly was the most abused drug (Oetting,

Beauvais, and Edwards, 1988). Marijuana, cigarettes, inhalants, stimulants, and cocaine ranked among the next most used drugs.

Oetting and his colleagues indicate that lifetime use prevalences has increased since 1975, the year they began their comprehensive study. Some of their more interesting findings show that: (1) 75% of Indian youth beyond the sixth grade tried marijuana; (2) 30% of their respondents tried inhalants; (3) one youth in 20 has been exposed to heroin; and (4) Indian youth may be exposed to stimulants, cocaine, sedatives, and tranquilizers at younger ages than nonIndian youth.

Bernard Segal at the Center for Alcohol and Addiction Studies housed at the University of Alaska in Anchorage tracked the drug use of Alaska youth from 1977 to 1988 (Segal, 1989). Segal's results closely resemble those obtained by the Colorado State University study group. His results show that Alaska Native students have the highest prevalence rate of any Alaskan ethnic group for ever having tried one or more drugs. Segal maintains that "the bad news is that Alaska's lifetime prevalence for adolescent drug taking behavior contrasts with national findings that reported a 'downward trend in the use of any illicit drugs'" (1989, p. 118).

The abuse of psychoactive drugs by Indian youth is not limited to reservation, rural and village settings as reported by the Colorado State and University of Alaska studies. All the indicators reveal that it has reached epidemic proportions in some Indian boarding school settings. May (1982) pointed out that many boarding schools are the repositories of high-risk or problem Indian youth and suggests that the environment is ripe for facilitating heavy drug use. Some survey results support his contention. Dinges and Duong-Trau (1989) showed that the lifetime rates for alcohol use in one boarding school reached 93%; 53% of their sample were considered to be "at risk" for serious alcohol abuse. In yet another boarding school King, Beals, Manson, and Trimble (in press) reported that for 85% of the total school population alcohol was the drug of choice followed by marijuana (75%). Twenty-five percent of the youth reported using alcohol every weekend and over 50% indicated that they have six or more drinks when they drink; of these 73% answered that they drank until they were "high" or drink. Using structural modeling techniques King and his associates found that the more youth at the particular

school experienced life stress the more likely they were inclined to experience depression and/or to use alcohol and drugs. The limited number of surveys concerning drug use in Indian boarding schools warrants serious attention since about 20% of the total Indian and Native student age youth are likely to be in attendance (U.S. Department of the Interior, 1988).

Alcohol use and abuse among Indian youth has received considerable attention and well it should considering the reported heavy use rates over many decades. Unfortunately, little attention has been directed towards understanding the use and abuse of other psychoactive substances. As of 1988, there were only 14 journal publications exclusively devoted to the Indian drug use topic; of that number 9 were commentaries and literature reviews that attempted to draw attention to the problem (Trimble and Bolek, 1988). There is more. Most of the drug and alcohol studies appear to focus on rural Indian youth. Therefore, little is known about drug use of Indians residing in America's urban settings where close to half of the total Indian population tend to reside. One can only speculate about the incidence and prevalence of drug use among urban Indian youth.

Prevention and Intervention

Published accounts of alcohol and drug abuse prevention and intervention approaches are restricted to a few researchers and practitioners. The paucity of published articles concerning the topic belies the attention and concern expressed by tribal and village leaders and residents. Therefore, there may be an enormous gap between the number of published accounts of prevention and intervention efforts and those that have occurred and are occurring in dozens of Indian communities. Most community efforts rarely are not carefully documented or subjected to the rigors of scientific research principally because the sponsors and community residents are most concerned about local outcomes. An example may help. In the mid 1980's a married couple residing on the Alkali Lake reserve in British Columbia, Canada openly declared their resolve to achieve total sobriety from alcohol among themselves, relatives, and close friends. In time, along with a good deal of pain, persistence, and patience and the support of many, the couple was able to move the community of nearly 400 to a level where slightly over 90% declared abstinence from alcohol; before the couples initiative around 95% of

the adult residents were heavy drinkers and alcoholics (NIHB Reporter, 1987). The success of the Alkali Lake residents might not have achieved any noteworthy attention if the story had not been documents and recreated on a film entitled "The Honour of All." The Alkali Lake experience occurred without the aid of a grant, use of measurement tools to evaluate the effectiveness of the intervention, and the scrutiny of outsiders interested in the phenomena for research purposes. By all standards, the Alkali Lake residents intervened and prevented alcoholism from totally destroying their valued community. Above all else, the experience confronted the despair of community alcoholism with hope and commitment that things can change.

In the late 1980's the United States' Office of Substance Abuse Prevention (OSAP) began supporting numerous projects that emphasized preventive-intervention efforts in numerous communities throughout the country. The OSAP administrators were specifically interested in supporting the development of innovative intervention models that emphasized high risk youth. By 1988 OSAP awarded 18 grants that targeted communities with sizeable American Indian and Alaska Native populations; some 24 tribes and villages were represented in the prevention activities; Fleming and Manson (1990) conducted an extensive evaluation of the characteristics and effectiveness of the 18 programs. The results of their assessment produced some interesting insights concerning the importance and significance of substance abuse prevention and intervention efforts.

Ninety-four percent of the community based programs emphasized primary prevention activities; primary prevention activities are developed for the purpose of preventing a health related problem from occurring among those who may be at risk. Some of the primary activities involved the use of educational materials, promotion of Indian identity and building self-esteem through cultural events, and the use of self-help groups. Individual and group therapy and counseling were found in 88% of the projects; secondary and tertiary levels of prevention tend to emphasize the use of counseling and psychotherapy hence the activities are intended to prevent a problem from intensifying and to intervene in hope of alleviating the problem.

Since the 18 programs were based at the community level the opinions of local staff were important in shaping the project's design to fit local needs and cultural perceptions. Sixty one percent of the projects reported that the success of the activities centered on improving relationships with their respective clients families; 56% felt that it was important to support and maintain open communications across all levels of the project's operation.

Fleming and Manson (1990) asked their respondents to identify those factors which placed Indian youth at risk for using drugs and alcohol. Eighty eight percent singled out poor self-esteem and parental abuse of alcohol as the greatest contributor to high risk. The respondents also identified additional contributing factors including: peer and friends use of drugs; abuse, neglect and family conflict; sexual abuse and emotional and psychological difficulties; previous suicide threats or attempts; and alienation from the dominant culture's social values. The researchers also asked their respondents to identify factors which presumably prevented one from using and abusing drugs. Protective factors listed include: youth who have a well defined spiritual belief system; a positive sense of self-worth; ability to make good decisions about personal responsibilities; and the ability for one to act independent of others influences. The respondents also believed that one's friends and peers who act in healthy and responsible ways can serve as models for those youth who are at risk.

Basically, Fleming and Manson were able to demonstrate that some Indian community members had a good sense for those social and psychological factors which contribute to drug use; they also seemed to recognize those factors which are essential to preventing the problems from occurring or getting worse. More to the point, many Indian communities appear to have keen insight into drug and alcohol abuse problems and the commitment and knowledge necessary to intervene. Communities may require technical and expert assistance in certain phases of prevention and intervention programs, however, such assistance is not an absolute necessity.

There is additional evidence available to demonstrate that many other Indian communities are actively involved in preventing substance abuse. Owan, Palmer and Quintana (1987) surveyed nearly 420 schools from Head Start to the secondary school level with large American Indian and Alaska Native

enrollments and 225 different tribal groups who were receiving grant support for alcohol and drug abuse projects form the Indian Health Service. Both the school and community respondents indicated that alcohol and drug abuse education was a major priority followed by a concern for building self-esteem and developing effective coping and decision making skills. Owan, Palmer and Quintana (1987) draw some important conclusions that emphasize the need for "early intervention to combat alcohol and substance abuse among Indian youths" (p. 71). They also emphasize the point that Indian youth need strong families in order to promote positive self-esteem, identity, and values. "Weak families," they argue, "produce uprooted individuals susceptible to 'peer clusters' prone to alcohol and substance abuse" (p. 71).

Conventional drug abuse clinical intervention and prevention approaches are patterned after the conventional norms of counseling and psychotherapy. As discussed earlier the match between the culture of Indian and native communities presents unique and complex problems. Yet a careful review of many of the drug and alcohol prevention programs in operation in many Indian communities shows that a good deal of borrowing and exchange occurs. Indian program staff identified education, self-esteem, identity, value clarification, and family dynamics as major factors which need attention. Respondents indeed did mention the need to emphasize the use of counseling and psychotherapeutic techniques wherever possible in their respective programs. The survey results suggest therefore that Indian staff are borrowing certain intervention techniques and approaches and blending them with local cultural lifeways and thoughtways. And the blend of approaches appears to be producing positive outcomes (Owan, Palmer, and Quintana, 1987).

A Behavioral-Cognitive Approach to Prevention-Intervention

During the past decade we have been exploring a blend of conventional psychological theory and local indigenous cultural lifeways and thoughtways in an effort to prevent Indian adolescent drug and alcohol use (Schinke, Schilling, Gilchrist, Barth, Bobo, Trimble, and Cvetkovich, 1985; Schinke, Botvin, Trimble, Orlandi, Gilchrist, and Locklear, 1988). Because of the unique bicultural and sometimes multicultural demands placed on American Indian youth prevention-intervention approaches must strike a

blend between psychological theory and the unique cultural circumstances. As a consequence of the blend Indian youth should be able to learn biculturally effective competence skills that "blend the adaptive values and roles of both cultures in which (youth) were raised and the culture by which type are surrounded" (LaFromboise, 1982, p. 12).

Learning biculturally competent skills has the capacity for Indian youth to make known their desires and preferences in Indian and nonIndian social milieus. Elaborating on the subject LaFromboise and Rowe (1983) emphasize that "a socially competent, bicultural assertive lifestyle involves being benevolently interested in the needs of the group, socially responsible to perpetuate a belief system that highly values personal rights and the rights of others, self-confident ... and decisive..." (p. 592). The subgoals of bicultural competence theory as outlined by LaFromboise and Rowe center on knowledge and skills in communication, coping, and discrimination skills serve as the core elements of our prevention approach.

Merging the learning of new thought patterns with the expression of appropriate behaviors to generate biculturally competent skills actually build on cognitive and behavioral principles drawn from social learning theory in psychology (Botvin and Wills, 1985; Schinke and Gilchrist, 1984). Briefly, the fundamental principles of social learning theory emphasize the relationship between our actions and thoughts and the social environment that witnesses and reacts to our actions. Ordinarily, most people act in ways that will produce some form of positive reinforcement; that is, what we may believe to be positively reinforcing. In the course of our transactions with others we achieve degrees of success which subsequently lead to beliefs about our efficaciousness (self-efficacy), our ability to function effectively in social settings (self-mastery), and a sense of worth as an acceptable person (self-esteem). And typically the reinforcement of our actions leads to the reinforcement of our feelings and beliefs that we are competent and effective. We can also acquire knowledge and skills by observing the behaviors of others -- presumably the more significant the others are in our lives the greater the influence on learning appropriate and effective actions. Social learning theory, therefore, is often referred to as observational learning.

The tenets of social learning theory can be organized around an instructional framework to accelerate the learning of new information and new life skills. Social learning theory also can be fused with certain fundamental counseling skills to equip adolescents with the ability "to handle current problems, anticipate and prevent future ones, and advance their mental health, social functioning, economic welfare, and physical well-being" (Schinke and Gilchrist, 1984, p. 13). Therefore, a prevention strategy can be organized that emphasizes "the way the individual combines information into a judgement of perceived behavioral pressure ... and efforts to modify other aspects of the intimate cultural (Huba, Wingard, and Bentler, 1980, p. 34). Youth, whether they are at a high risk or not, can learn to inoculate themselves against peer pressure to engage in dysfunctional behavior such as drug and alcohol use.

Components of Life Skills Training.

In our drug abuse prevention training and research the methods and approaches are organized in such a way that they can be used by Indian youth and conducted by American Indian paraprofessionals, teachers, counselors, and parents. The methods center on providing information intended to change knowledge and attitudes, assisting with problem solving, providing opportunities to formulate and use coping statements, improving interpersonal communication skills, and promoting the organizing of supportive "peer clusters" and social networks.

Social modeling, another inherent fundamental principle of social learning theory, forms the nexus of the prevention effort. The use of social modeling is grounded in the finding that "Indians have an overabundance of opportunities for learning and for performing 'drinking' behaviors, ... in this case excessive drinking would not be deviant behavior, it would conform to the expected modes of excessive drinking and the undesirability of nondrinking" (Escalante, 1980, p. 201). Peers do affect drug use behavior among youth. Plant (1975), for example, found in his survey that "all respondents attributed their first drug experiences to the direct influence and encouragement of friends" (p. 76). Similarly, Oetting and Beauvais (1986) concur with Plant. Based on almost a decade of drug use survey research

among Indian youth the Colorado State University researchers argue that actual drug use is directly and intimately linked to involvement with peer clusters.

Oetting, Edwards, and Beauvais (1989) point out that Indian drug use is initiated and quite often supported by peers. They maintain that "peers help teach a youth how to use drugs, often provide the drugs, and provide personal and emotional support for using drugs" (p. 23). Peer influences are the dominant forces in promoting Indian drug use; but peer influences through social modeling can be a powerful tool in preventing and treating drug use. It is ironic that some of the very components used by peers to promote drug use (e.g., information, communication, support networks) can be turned around to inoculate one against peer influences.

History and Background.

In the early 1980's a behavioral-cognitive skills enhancement program designed to prevent drug use among Indian adolescents was implemented under controlled conditions in the Pacific Northwest (Schinke et al., 1985; Gilchrist, Schinke, Trimble, and Cvetkovich, 1987). To assist in organizing and implementing the project and in designing the cultural components of the training curriculum an Indian advisory committee was formed; the formation and use of an Indian advisory committee is an absolute must for any prevention-intervention effort to be initiated and implemented. I keeping with local Coast Salish tradition in the Northwest the project was named La-quee-biel (to prevent) by a prominent Indian doctor (shaman) from one of the participating reservations. The intent of La-quee-biel was to determine the feasibility of blending social learning theory with local Indian cultural lifeways and thoughtways and assess the impact of the blended perspective.

The 12 member Indian advisory board met regularly to review, critique, change and approve the implementation plans, curriculum, and intervention materials. The board also assisted in identifying communities where the intervention eventually took place. And the board also monitored the pilot testing of the intervention materials. During the course of the intervention phase of La-quee-biel the board was provided with progress reports and summary analysis of the research findings.

During the period from the fall of 1984 to the spring of 1985 a total of 102 Indian youth participated in the prevention effort at three intervention sites (one urban and two rural). Numerous pieces of information were collected from the youth in an effort to assess the effectiveness of the intervention approach. Overall, the analysis of the measures modestly support the potential for a bicultural competence skills intervention approach among American Indian youth. Gilchrist, Schinke, Trimble, and Cvetkovich (1987) report that at a six month follow-up Indian adolescents who received the skills enhancement program had lower rates of alcohol, marijuana, and inhalant use when compared with their peers who did not receive the skills training. Although the number of Indian youths who participated in the intervention approach was relatively small, the overall effort generated a good deal of enthusiasm from a number of constituent groups.

Organization and Implementation.

The use of our bicultural skills enhancement approach occurs in four phases: 1) Establishing community collaborative relationships and the formation of an advisory or steering committee; 2) designing the intervention and curriculum to accommodate and incorporate local Indian values, customs, and lifeways; 3) training local Indian indigenous community paraprofessionals; and 4) conducting the intervention scheme with local Indian youth. The following discussion will present the essential components of the third and fourth phases.

Training Paraprofessionals.

Local Indian community residents especially parents, tribal leaders and those with paraprofessional training in mental health and substance abuse fields are invited to serve as small group leaders. For about two months the small group leaders and training staff meet for 16 two-hour sessions to review and study the content and approaches needed to conduct the cognitive-behavioral prevention scheme. The training curriculum emphasizes an orientation to the problem, rationale for using the cognitive-behavioral approach, drug and alcohol knowledge, drug and alcohol use among Indian youths, problem solving, decision making, self-instruction, personal coping, interpersonal communication,

homework, and small group dynamics. The essential thrust and focus of each of the training components are highlighted below.

Orientation and rationale. The trainers emphasize the history, incidence and prevalence of drug abuse in the United States. Attention then is directed to the nature of drug abuse among American Indians. Sufficient attention is given to social learning theory and the cognitive-behavioral perspective. An attempt is made to demonstrate the linkages between Indian drug use and the core principles of the cognitive-behavioral prevention approach.

Drug knowledge. Our early training efforts revealed that many Indians had misconceptions, inaccurate knowledge, and held stereotypic views about drugs and alcohol. Hence, some time is devoted to providing the group leaders with factual information about the recreational and medicinal uses of drugs frequently used and abused by Indian youth. Since the discussion and learning of factual information is a key element in the cognitive-behavioral approach it is essential that the group leaders are well informed.

Drugs and Indian youth. The instruction of drug and alcohol knowledge and information must be structured to reflect an adolescent's orientation to learning. During this training element group leaders learn the importance of relating drug and alcohol use to the daily experiences of Indian youth. Moreover, group leaders need to learn to create a nonjudgmental atmosphere where Indian youth feel comfortable in discussing their personal experiences and asking questions about drug use without fear of being criticized or reprimanded.

Problem solving. Group leaders are provided instruction in recognizing drug use problems, developing solutions to deal with the problems, and applying problem solving steps. In essence, the paraprofessionals learn to use the problem solving strategies on themselves and then teaching them to one another. In this component, the trainers provide feedback, offer praise and offer suggestions where needed.

Decision making. Problem solving of any kind requires one to identify and make appropriate decisions. In this component, trainers and group leaders review a series of short case studies and

subsequently generate and rank solutions. Each solution to the individual's problem in the case history is reviewed thoroughly. Group leaders also attempt to master the decision making process even to the extent of incorporating it into their own lives. The following example is a sample vignette typically used in the exercise:

> Fifteen-year-old Lonnie and his friends get stoned during the school lunch hour. Lonnie likes his friends and wants to stay buddies with them. Yet he knows his school work fails after he smokes dope. Lonnie defines the problem as feeling he has to go along with the gang. Further specifying the problem he sees that either he or his friends must change the non-hour pattern. Since Lonnie has limited power over his friends and major influence over himself, he reasons that he will be the one to change.
>
> Lonnie generates a range of solutions. He could hang out with his friends and just take a few hits off each joint. That way he might not get too stoned. He could say he has a sore throat. He could stay inside school over the lunch hour. He could pretend to smoke dope but not inhale.

Self-instruction. There is an intimate almost inextricable relationship between knowledge, problem solving, and decision making and the behavior one chooses to emit. Trainers instruct group leaders how to use "inner speech" to guide overt behavior. Self-instruction can provide one with the ability to control and regulate drug use behavior. Group leaders are asked to practice self-instruction in their daily life experiences. A good deal of training time is devoted to sharing self-instructions in small group settings. Self-instruction is a major component of the cognitive-behavior approach and therefore it must be thoroughly learned.

Personal coping. This training component often generates very lively discussion and active participation in part because many people believe that moderate forms of drug and alcohol use can help one to deal with stress. Group leaders are taught how coping self-statements (a form of self-instruction) and coping activities help people enact responsible, unpopular decisions. Group leaders are asked to generate thoughts and corresponding actions and then adhere to them. Such statements have been:

"Even though I really want to get loaded, I'll feel awful later." "I've handled problems like this before." "The pressure is getting bad; I'm going outside and take a long walk." Coping with problematic and potentially stressful life-events does involve advanced planning and even rehearsal. Group leaders are asked to act their coping strategies through role play and psychodrama. The activities centered in this component help group leaders to assess their own coping skills and assist them in practicing the instruction of effective skills to others.

Interpersonal communication. In this component self-instruction and personal coping strategies are linked to the development of interpersonal communication skills. Group leaders will learn and act out nonverbal and verbal behaviors that minor drug-avoidance knowledge and intentions. Group leaders role play youth who are attempting to stay away from drugs. Trainers serve as antagonists, coaches, and sources of feedback. In many sessions, Indian group leaders actually relive their adolescent experiences with drug and alcohol use. In this component, many come face to face with the peer pressures than either they engaged in or were used with them in social situations. A good deal of individual practice is required in this component; trainers and small group members must be convinced that the individual's refusal skills are genuine and hardfast.

Homework. Learning self-instruction, problem solving, and decision making skills group leaders and eventually the youth themselves must practice. Homework emphasizes the learning process and reinforces use of the skills. Trainers negotiate assignments with the group leaders to practice drug prevention activities in the natural environment. Group leaders are asked to expand their drug knowledge by searching out up-to-date materials, referral sources, and community programs. During training sessions group leaders spend some time reviewing their progress on their out-of-session assignments. Finally, they devote some time to rehearsing the training of youth to negotiate their eventual homework activities.

Small group dynamics. Group leaders must learn the basic elements of small group leadership; they will merge the cultural norms concerning small group processes with those that are known to be effective in the general social sciences literature. During the training, group leaders watch, practice, and

teach all of the cognitive-behavioral prevention components. At strategic junctures, the trainers relate small group experiences to generalized situations so that the group leaders can lead youth through the prevention activities. Trainers emphasize group confidentiality, subgroup sabotaging, homework, faking, and what to do with youth who arrive high on drugs and alcohol.

When the training of the group leaders is completed they have learned essentially all of the components that comprise the cognitive-behavioral prevention program. They have received the basic rudiments of group dynamics, interpersonal communication, and problem solving skills. Throughout the training group leaders are encouraged to modify the small group techniques with those cultural specific norms and values particular to their community. In forging a blend between two sources of knowledge the group leaders mold a style that captures the basic knowledge of human dynamics and those cultural norms that operate best in the community.

Prevention Program

The components of the cognitive-behavioral prevention intervention program are basically those learned by the group leaders during their training. By way of review they include providing information and changing attitudes, assisting with problem solving, formulating coping statements, improving interpersonal communication and organizing social networks (Schinke et al., 1985). Indian youth of similar ages are trained in 10 member groups, meet twice weekly for 15 two-hour sessions over two months. Group leaders, with the assistance of resource people, use didactic methods, guest speakers, audiovisual materials, discussion, experiential procedures, and homework to work through the basic components. The basic goal of the training is to assist Indian youth to infuse cognitive-behavioral prevention into everyday avoidance of drugs. For youth, training is meaningful when they can choose and maintain lives that do not depend on drugs.

Activities that occur in the 15 sessions are listed in Table 1. An abbreviated substance of the sessions is presented below using the program's components as guidelines. It should be pointed out that most of our prevention-intervention conducted over the past six years occurred in community based settings such as neighborhood facilities, tribal centers, and tribally controlled schools; in a few instances

Table 1

Schedule of the Cognitive-Behavioral Skills Prevention Program

Sessions	Topics
1	Introduce program rationale.
2	Discuss fictions concerning Indian drinking and drug use. Discuss the impact of stereotypes on behavior. Complete a self-esteem promotion activity.
3	Review health education information on drugs and alcohol through games, films, handouts and posters.
4	Discuss factors that encourage drug use. Introduce peer guest speaker to share personal reasons for rejecting drug use.
5	Discuss the role of values in decision making. Complete activities to encourage identification of personal values. Introduce the S.O.D.A.S. problem solving method.
6	Focus on the "S" (Stop) and the "C" (Options) of the S.O.D.A.S. model. Teach students to identify "tough situations" and cope with stress. Practice brain-storming techniques.
7	Focus on the "D" (Decide). Practice consideration of personal goals, personal values, and drug-alcohol facts during decision making. Use S.O.D.A.S. to solve drug and alcohol problems.
8	Focus on the "A" (Act - communication skills) and the "S" (Self-praise). Use communication skills.
9	Use comic books and overhead projector to practice using the S.O.D.A.S. model to generate refusal statements for tobacco, alcohol, marijuana and inhalant abuse.
10	Participation Videos are used for students to practice S.O.D.A.S.-generated refusal statements (S.O.D.A.S. and response prompts).
11	Students create their own answers (S.O.D.A.S. prompts but no response prompts) for participation video situations in Lesson 11 and engage in group practice.
12	Generalize use of S.O.D.A.S. to non-drug and alcohol problems. Use puppets and story boards to practice skills.
13	Provide additional practice by working with other students to create a S.O.D.A.S. "Commercial" on videotape.
14	Finish videotaping. Review drug-alcohol facts. Introduce adult guest speaker from tribal alcohol treatment program. Obtain student evaluation of the program.
15	Summarize S.O.D.A.S. Outline plans for follow-up. Discuss termination concerns. Enjoy a farewell party.

local public school administrators offered the services of their facilities. Use of tribal facilities though appears to provide an atmosphere best conducive to trust; such locations also enhance the perceived cultural relevance of the training.

Orientation. Group leaders lay out the ground rules and emphasize punctual attendance, confidentiality, active participation, honesty, positive feedback, and a nonjudgmental atmosphere. An overview of the substance of the 15 sessions is presented.

Knowledge of drugs. Discussion emphasizes the nature of various kinds of psychoactive drugs. Films, slides, videotapes, and overheads are used to supplement the didactic process. Instructional self-tests, take home brochures, and summary facts sheets are circulated. For homework youths are asked to gather supplemental drug information from home and community resources. To emphasize and promote positive attitudes guest speakers are also invited to discuss their personal successes in life that occurred through nondrug use means.

Problem solving. Based on their own training experiences group leaders present material to help youth understand problem solving to gain an awareness of its usefulness in personal, daily situations. Youths are encouraged to identify and discuss problem solving approaches in small group sessions.

Decision making. Based on the solutions generated form the problem solving component youths are asked to judge the solutions, develop a plan to implement them and estimate and discuss others' reaction to them. Youths learn that problems can be broken down into small manageable segments. Through the process youths learn that drug and alcohol problems are commonplace but that they can be managed.

Self instruction. Essentially youths are taught the value of inner speech using one's daily routines as an example group leaders model the self-instruction process; inner speech is used to describe an activity one is engaging in and identify the feelings associated with each. Group leaders rehearse the activity with the youth eventually leading them to discuss thoughts for implementing drug

use avoidance decisions. Practice is essential to achieving success with this activity. An example may help illustrate the interaction that occurs between the group leader and a youth:

Leader: "Sharon, why don't you run through the self-instructions for carrying out your decision. Practice what you'll say to yourself when your friends start doing drugs and want you to join in. Describe the situation as you imagine it will happen."

Sharon: "OK. Pretend like me and the girls are over at Ronnie's. We're just sittin 'round, listenin' to records. Ronnie came out of her bedroom carrying her stash box. Everybody is gonna get high, and I don't want to."

Leader: "All right. Does everyone have the scene? Sharon, say out loud self-instructions you will be able to use. Don't be embarrassed. We're your friends. Nobody will poke fun at you."

Sharon: (taking a deep breath) "Oh, oh. Ronnie's got her stash. The girls are gonna smoke. Ronnie will probably pass around white crosses like she usually does. I don't want to do none of that stuff. I know I can turn it down. When Ronnie brings the stash by me, I'll say 'Uh, uh, not for me Ronnie. I'm not doing much dope these days.' If Ronnie or anyone else makes trouble I'll say 'Hey, back off!' and will get up and go to the john. When the hassle is over I'll say 'Sharon, you're cool. You didn't do any dope and everything turned out just fine!'"

Leader: "Super! Those are great self-instructions, Sharon. Let's go through the scene again. This time whisper your self-instructions."

Sharon: "OK." (Sharon subvocalizes the same thoughts.)

Leader: "Swell! Now say the self-instructions inside your head."

Sharon: (sits silently for a moment.)

Leader: "Real good. Anyone have feedback for Sharon?"

Rhonda: "Yeah, I do. Those are neat things to say Sharon, but when you think them don't close your eyes. The girls might think you've gone weird. If you gotta give yourself time to think, why not look down at the floor a minute?"

Leader: "Good suggestion. Anyone else?"

Group members are encouraged to try out self-instructions in a variety of situations where drugs and alcohol may be used. Feedback, support, and rehearsal are important components of the activity.

At this point in the training youths are introduced to the acronym, S.O.D.A.S; it stands for Stop (what's happening in the situation?), Options (what are my options?), Decision (what decision can I make now?), Act (act on my decision), and Self-praise (praising oneself for making a positive, healthy decision). Buttons, posters, leaflets, and small soda-pop cards are circulated among the youths blazened with the S.O.D.A.S. acronym. In the course of the training, especially during the self-instruction component, youths are encouraged to use the acronym to guide them in their thoughts and actions. Experience tells us that youth remember the S.O.D.A.S. acronym long after they completed their training; many actually refer to the training as the "SODAS project" or that "SODAS person" (referring to the person who coordinated the training).

Personal coping. During this session youths are given opportunities to identify and practice coping responses that will assist them maintaining their drug avoidance decisions. Inner thoughts concerning refusal skills must be turned into proactive and positive overt behaviors, that is, one's self-instructions must allow for the immediate use of effective coping strategies. It's important that youths practice the personal coping procedures to the extent that they achieve some sense of mastery.

Interpersonal communication. Group leaders introduce this component by discussing postures, expressions, gestures and verbalizations that occur in drug using situations with other people. Styles of nonverbal and verbal communication skills used among Indians are discussed. Group leaders indicate that subtle cues can unintentionally lead people to encourage one another's drug use. Even when motivated, youths especially may have trouble refusing invitations to use drugs.

During the session group leaders point out how youths current communication styles can skew drug use and nonuse. Leaders also discuss and model communication patterns that unambiguously show drug-avoidance decisions. Youths practice their styles in dyads and then engage in group feedback sessions. The following is an example of one of the structured situations used in the session:

> Act out this problem in your subgroup. Use postures, looks, and words like the leaders used. Give feedback after each practice. Remember to be positive and helpful. Switch roles so everyone can practice.
>
> You and your friends are hanging out at the Seven-Eleven. Dave wants you to go with him to Bernie's and score some dope. You don't want to.
>
> Dave: "Hey, let's you and me cut to Bernie's. He's got some fine weed."
>
> You: _____
>
> Dave: "What are you sayin'?"
>
> You: _____
>
> Dave: "What's the matter with you?"
>
> You: _____
>
> Dave: "Quit stalling. Let's go."
>
> You: _____
>
> Dave: "Some friend you are!"
>
> You: _____
>
> Dave: "Are we together or not?"

Group leaders move from subgroup to subgroup giving youths feedback, coaching, and praise. The youths comfort and skill in structured situations signals their readiness to handle individual problems with substance abuse. Group leaders and youths continue to identify ways to take charge of temptation and pressure. Continued practice and rehearsal can inoculate youths to the obstacles of drug avoidance.

Homework. Homework ties together all previous training components. It moves drug prevention into youths' homes, schools, jobs, peer groups, and communities. It may even lead to parental involvement. Homework assignments are negotiated at every session and monitored at the beginning of the following session. Youths must know that the responsibility for completing rests with them. Group leaders in turn provide social reinforcement for successfully completed assignments, respond directly to noncompletion, and ignore fabricated reports.

Examples of the types of homework we have used include: 1) obtain additional information about drugs and alcohol; 2) tell someone at home or school about a guest speaker's presentation; 3) practice problem solving and decision making skills in real life situations; and 4) report on situations where someone's refusal skills have been successful. The assignments provide opportunities for the youth to practice and polish their skills. They also provide forms of prognostic information that can raise interesting discussion questions such as: 1) Do youths think drug-avoidance decisions can be carried out?; 2) If so, how will they deal with responses from other people?; 3) Are youths entertaining a range of options and contingency plans?; 4) What if decisions are greeted unexpectedly?" 5) Can they handle a physical response?; and 6) How about decisions me with disinterest and silence?

The final session of the intervention is set aside for reviewing all of the basic components of the training and to celebrate the completion of the program. Youths are given certificates at a small awards ceremony. This is followed by a blessing from a spiritual elder from the local community. And then a small feed is arranged where parents, community leaders and concerned residents are invited to share in the success of the youths experience.

Did La-quee-biel work? Did our cognitive-behavioral prevention plan have an impact on the drug avoidance skills of the youth? The answers to both questions are in the affirmative. The group leaders and youth did learn something; analysis of our data collection tells us so (Gilchrist, et al., 1987; Schinke, et al., 1988). But the prevention-intervention methods must be approached with a degree of healthy skepticism. Part of our assessment plan involved a three and six month follow-up. And in some instances we painfully learned that some of our youth did engage in drug use at least at an experimental

stage. One 12 year ole "user" told us: "I really liked the SODAS course. I learned a lot and I thought I could handle my friends. At home it's different. My mom drinks and smokes and so does my uncle. I see them drunk all the time and it hurts because it's my mom. And I say 'They do it so it must not be so bad.' I'm confused sometimes." Youths can learn and benefit from the program, however, for the training to be effective it must have home and community support. Teaching youths prevention skills within the context of a community rife with drug and alcohol use is likely to create emotional tension for them, cause them to question what is normative, and erode respect and allegiance to kin.

Conclusion and Implications

The chapter begins with a discussion of the problems of using conventional and traditional forms of psychotherapeutic and counseling interventions with American Indians and Alaska Natives. Numerous points are made. One must recognize that cultural specific forms of psychological and behavioral intervention and prevention have existed in Indian and Native communities for centuries. Vestiges of traditional healing and treatment ceremonies persist to this day although many have been revised to accommodate contemporary Indian and Native lifestyles. Use of conventional clinical intervention approaches in culturally distinct communities must forge a blend with the local ethos and eidos in order for some modicum of success to occur.

Emphasis is subsequently placed on the alarming prevalence and incidence of drug and alcohol use in Native and Indian communities. Some epidemiological data is provided to demonstrate the essence of the problem. Summary information is provided showing that numerous Indian and Native communities are working through a variety of prevention and intervention schemes in an effort to deal with drug and alcohol use. At a general level it's clear that the communities rely heavily on the conventional wisdom and methods of the substance abuse research field; however, the community resource people recognize that intervention schemes must be adjusted to fit local tribal specific customs and norms.

The chapter proceeds to a discussion of cognitive-behavioral prevention, bicultural competence, and social skills enhancement. All three perspectives have been brought together to form

a drug use prevention-intervention strategy tailored for use with Indian youth. Descriptions of the theory and history of the strategy are presented. Details describing the training of local indigenous community people are presented along with the key components of the cognitive-behavioral prevention plan. This is followed with a description of the plan; examples and a table are included to illustrate more unique aspects.

As a stand alone prevention-intervention strategy the cognitive-behavioral perspective probably would not be very useful. The content of the components, exercises, interpersonal communication styles, and didactic approaches must be adjusted to fit the cultural lifeways of a community. Local people also must be included in the planning and curriculum adjustment and modification phase. And they should also be trained to serve as group leaders. The cognitive-behavioral skills enhancement prevention strategy, therefore, can be used in many culturally different communities; it does lend itself to translation into Spanish for use with Latino populations.

Our prevention strategy is adaptive, flexible and amenable to revision to accommodate different cultural perspectives. At one level the strategy focus on youth and at the individual level. Yet when viewed from another perspective the strategy is engaging as it requires the cooperation of many. And this is the strategy's major strength. We have learned that the community where the training occurs must be collectively supportive, must take a stand against local drug and alcohol abuse, and must be active in promoting prevention and intervention approaches that meet local needs.

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